MARKETIZATION OF ELDERLY CARE IN SWEDEN*

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ABSTRACT

Ten years have passed since the Swedish government widely encouraged its municipalities to marketize their elderly care services. There has been a long-standing discussion on the benefit of marketization during that period, but most of the discussions were developed from the case studies of a limited number of municipalities. With lately available statistics, the present study tries to find some general rules across many different municipalities. Regarding the motives of the municipalities for marketization of elderly care, there is apparently a tendency that municipalities with stronger bourgeois ideology, more serious shortage of care supply, larger size of caretakers and higher population density are more likely to rely on privately managed service. As for the effect of marketization, it is shown that the cost performance is better in those municipalities allowing the participation of private providers than in other municipalities. However, this effect seems to have significant negative association with the strength of bourgeois ideology. This implies that the municipalities with strong bourgeois ideology tend to consider marketization as a purpose by itself rather than a means to achieve better cost performance.

KEYWORDS: elderly care, market competition, Sweden, municipality

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1. INTRODUCTION

Sweden had long been reputed as a 'public service state' along with other Nordic states. Generally speaking, the state is more heavily engaged in the organization and financing of social services under more generous and socially redistributive schemes than other developed countries (Ervik and Kuhnle 1996; Lehto, Moss and Rostgaard 1999). Consequently, the share of the public sector in total employment was as much as 31.7% in 1990 (Rosen 1997). In the same year, the proportion of total government expenditure to gross domestic product (GDP) was 59.1%, which was over 20 point higher than the average of OECD countries (Norrman and McLure Jr. 1997). The amount of public social expenditure was as high as 32% of GDP in as early as 1990, which was far greater than the corresponding figures of other European Union members (23% on average), Japan (11%) and the United States (14%).

While generous public financing was largely preserved, the management of social services became more and more open to the private sector during the 1990s. The share of contract-based activities in total social services reached 10% in 1998 and continued to increase in the following year (Svenska Kommunförbundet 2001a: 11). However, it is true that this so-called 'marketization' does not mean the total disengagement of the public sector. It may be fair to say that marketization ideas 'never achieved the penetration which they enjoyed in Australia during the 1990s or New Zealand and the UK during the 1980s' (Pollit and Bouckaert 2000: 262). After all, public providers are still active in parallel with private ones, and the change occurs at the level of local authorities (municipalities) and not of the whole state.

Nevertheless, the recent spread of marketization is far from negligible. In the field of elderly care, the market-oriented reform was accelerated after the large-scale reform of the elderly care system called "Ädelreformen" in 1992. The aim of the reform was to integrate the function of elderly care under the municipal responsibility, and not to promote marketization. Yet the transformation of the existing framework gave many municipalities an opportunity to carry out the marketization reform. Once municipalities have decided to carry out systematic changes,

they are able to do so, now that the new scheme provided them with an integrated responsibility for elderly case. Accordingly the share of private service in terms of the cost (including the care for the handicapped as well as for the elderly) grew from around 1% in 1991 to 8.0% in 2001 (Lefwerth and Nordström 1992; Svenska kommunförbundent and Statistiska Centralbyrån 2002). In 2001, almost a half (49.5%) of the municipalities are dependent on some sort of private caregivers for home help service and/ or special housing accommodation. The shares of the elderly receiving private home help service and special housing were 7.8% and 12.4% respectively (Table 1).

Table 1 The shares of the elderly receiving private services, 1993-2001

Year	Home help service	Special housing accommodation
1993	3.6	5.4
1994	3.4	7.1
1995	3.9	8.3
1996	3.3	9.3
1997	4.2	10.2
1998	- a)	9.8 b)
1999	6.0	9.7 c)
2000	7.3	11.6 d)
2001	7.8	12.4

Note: a) Information is missing. b) The survey date is changed from 31 December to 1 November. So-called 'occasional' and 'part-time' residences (avlösnings- och växelvårdsplatser) are not included. c) Permanent residents on 1 November and Short-term residents in November. d) The survey data is changed from 1 November to 1 October. Both permanent and short-term residents are referred.

Source: Socialstyrelsen (2001); Socialstyrelsen (2002)

The spread of marketization is followed by many remarkable studies of this phenomenon.

With only few exceptions[1], however, previous studies focused on one or few particular cases, presumably for lack of official comprehensive statistics about the activities and finances exclusively for elderly care. All case studies have important implications, but they are not independent of the particularities of the municipalities/ municipality districts they observed. In addition, there is virtually no literature in English on this subject.

Yet the availability of relevant official data has been improved in the last few years, even though it is not abundant yet. By use of those data, the present study aims to discuss the general trend and effect of the marketization reform across all municipalities in Sweden, as far as the data availability permits.

The following part discusses the motives and effects of the marketization of Swedish elderly care. Three hypotheses are presented in the second section, and those hypotheses are tested by the model analysis in the third section. This is followed by some conclusions in the final section.

2. MARKETIZATION OF ELDERY CARE: MOTIVES AND EFFECTS

Motives for marketization

As noted above, not all municipalities are active in marketization. While nearly a half of Swedish municipalities adopt private providers to their elderly care services, the majority do not. This leads to the question of what type of municipality applies the marketization scheme more willingly than others.

When asked about the motive for marketization of elderly care services, almost all municipal officials and politicians interviewed by the author mentioned the improvement of the quality of their services as the primary goal. However, this does not mean that those municipalities not

[1] Recognizing the prevalence of case-oriented studies, Fölster (1993) conducted an analysis based on the database that included 60 reform cases and 36 non-reform cases. However, he did not specify municipalities/ municipality districts he selected, nor did he indicate the criteria of his selection.

marketizing their services are indifferent toward the quality of their services. Therefore the question is why certain municipalities are motivated to choose marketization in order to improve the quality of their services.

One of the most plausible explanations is political ideology (Socialstyrelsen 2000a: 9). Marketization of social services has been advocated most by the "bourgeois" parties, especially the Moderate Party. In fact, when they formed a right-block coalition from 1991 to 1994, the government organized the Competition Committee (Konkurrenskommittén) to promote marketization of various municipal works. With the emphasis on market competition and efficiency, they criticized the traditional public monopoly over social services. The Social Democratic Party (SDP) and other left-side parties, by contrast, tend to stress the danger of leaving social services to private caregivers, especially profit-driven companies. Although they get more and more positive about market competition, they are generally more cautious about the introduction of market competition into social services, believing that it may harm stable service provision. It may also be argued that the politicians in the left block is more reluctant for marketization than their oppositions, as it may well destabilize the working status of municipal workers, who are heretofore among the most important voters for them.

The share of elderly population in the society may also affect political choice. An opinion poll shows that elderly people are not generally concerned about the difference between public and private management, but some interviewees suggest that elderly people would be upset by the replacement of the staff, or the change of the care program. Since the introduction of private providers can potentially cause those changes, politicians may be more cautious in marketization when they have more elderly residents (i.e. voters) in their municipalities. Conversely, it is expected that municipalities with less elderly population may become more active in introducing the marketization reform. However, it may also be said that municipalities with more elderly population are more interested in marketization, since they are more likely to suffer from the financial problem and more willing to lower the costs. Hence the prediction of

the effect of this factor is ambivalent.

Another factor that may affect the motive of municipalities for marketization is the short supply of care. As a result of generous welfare system, Swedish municipalities often suffer from financial problem. The aging of the society has multiplied the problem both by increasing the number of caretakers and by decreasing the number of taxpayers. Consequently, few municipalities seem to be offering a sufficient amount of care, particularly with regard to special housing accommodation. Around 8% of the people over 65 years old are living in special housing accommodation right now, but this does not mean that all of the remaining 92% are happy to stay at home. In fact, nearly 5,000 people stood in the queue to get a place in special housing accommodation in 2000 (Dagens Nyheter 9 February 2001). Municipalities need to lower the cost per unit in order to increase the number of units, unless they can expect a large growth of budget income. Marketization is often discussed in that context, since it is supposedly helpful for cost reduction.

Besides the motives shown above, the choice of municipalities also depends on the technical feasibility of marketization. The size of caretakers may be important in this respect. Obviously, it is easy to create a share for private providers when there are a large number of caretakers. Conversely, if there are only a few special housing accommodations, it may be extremely controversial to privatize one of them. Home help services and other types of care for the elderly at home also need certain size of unit scale, and it is difficult, and perhaps economically unreasonable, to divide a small amount of work into municipal and private parts. Moreover, if the size of caretakers is small, the size of the municipal administration is small, too. It is then difficult to divide the administration staff between those in charge of the selection of private providers and those in charge of the management of municipal care to prepare for marketization. Even though marketization is administratively possible, private providers may not be interested to enter into the market if there is no economy of scale.

Private providers may also be reluctant to enter into the municipalities with sparse

population. After all, it is more costly if caretakers and their accommodations are spread geographically. It may also be more difficult to find human resources to be employed in sparsely populated regions. In general, recruitment in the welfare sector is a problem in many municipalities. According to the survey of Socialstyrelsen (the National Board of Heath and Welfare) in 2000, for example, over 80% of the interviewed municipalities felt that the recruitment of nurses was either 'much difficult' or 'quite difficult' (Socialstyrelsen 2000b).

From the viewpoint of recruitment, the relative size of elderly population may also be significant, but again, the effect may be ambivalent. For private providers, they may be more reluctant to enter into the municipalities where young human resources are more difficult to find. For municipalities, on the other hand, they may have more interest to rely on private providers when it is more difficult to recruit care workers on their own.

To summarize, the above arguments are formulized into the following hypothesis:

Hypothesis 1: Municipalities with stronger bourgeois ideology, more serious shortage of care supply, larger size of caretakers and higher population density are more likely to adopt private providers for elderly care services than others, while the effect of the relative size of elderly population is ambivalent.

There has been a study that examines the association between several explanatory factors and the attitude of municipalities toward marketization for elderly care services (Trydegård 2001). However, the study did not only deal with elderly care but also other welfare services, and the explanatory factors applied to the model are not tailored specifically for elderly care. Its analysis indicated that the share of private elderly care services, in terms of the number of private employees, has a strong positive association with the share of the votes for the Moderate Party, a moderate positive association with the whole population, a strong negative association with the share of lower-educated people in the population as well as a weak negative association

with the general service level of the municipality (Ibid.: 120). Presumably, the size of the whole population might be related with the size of the caretakers. The share of lower-educated people and the share of elderly population might correlate with each other. The general service level might reflect the supply-demand balance of elderly care. In any case, however, the study does not articulate why those variables are incorporated into the model, nor does it interpret the result of the estimation. Therefore it is still worthwhile to conduct an analysis with a set of the explanatory variables indicated in the hypothesis.

Effects of marketization

The effects of marketization of elderly care services has been one of the most controversial issues in Sweden during the 1990s. The main question in earlier discussions was whether private providers perform more effectively than municipal ones. Various studies were conducted, and their conclusions were diverse. According to the literature review by Socialstyrelsen (the National Board of Heath and Welfare) in 1996 (Socialstyrelsen 1996), the answer of this question is twofold. First, contract-based providers were on average less costly than municipal ones. Second, it is not very clear whether contract-based services provided better quality than municipal services.

The first point is not very surprising. This is not because private management is superior to public management, but rather because private providers could not enter into the market without cost advantage in many cases. As newcomers, they were (or were regarded as, at least) less competitive in terms of their knowledge about services and customers. They could argue that they would offer better services, but it was very difficult to replace incumbent municipal providers without appealing their cost advantage. It should also be remembered that private providers often fail even though they offer lower prices, since the selection of providers has rarely been decided by genuine price auction. For their success, private providers should often offer prices significantly lower than their municipal rivals.

Against this background, the second point is also quite understandable. Even though private providers made efforts to be more cost-effective, they were often constrained by strict financial conditions from the beginning. Furthermore, it should be noted that the replacement of management does not necessarily mean the replacement of the staff, especially those working on site. If a private company acquires the management of services from a municipality, it is obliged to employ the staff that has been employed by the municipality by that time[2]. In other words, there is no difference between municipal and private management from caretakers' point of view. Most of the staffs are the same, even if their employer is replaced. Of course, the placement of the staff often changes under the new management, but this may cause a rather negative effect on the quality evaluation by caretakers. Since caretakers' needs are very diverse, it takes much time for new caregivers to adapt themselves to those needs. While caretakers often appreciate new practices brought from new providers, those schemes did not always compensate for the breakdown of traditional personal continuities.

While the debate on those points has long continued, the public-private dichotomous comparison seems to have become less important. After all, the entry of private providers seems to have changed the management of municipal providers. After observing six municipalities with relatively long history of marketization, Svensson and Edebalk (2001) remarked that 'there is no clear difference between a private and a municipal provider with regard to the working manner' (p.33).

Presumably, the exposure of market competition has given municipal employees a good incentive to improve their services. It is true that their working status will be preserved even if they are taken over by private owners as stated above, but they are usually reluctant to leave the current status due to uncertainty under a new regime. Therefore it is not surprising that municipal managers are encouraged to learn new practices from private providers to improve their competitive advantage, just as private companies are engaged in "competitor analysis"

[2] According to Lagen (1992: 1528) om offentlig upphandling (the Law about public disposition).

(Porter 1980). It may also be important that the recurrent process of provider selection (i.e. bidding) provides a more effective monitoring than before. Even though municipal providers are allowed to continue their services, the performance of their services is now regularly compared with that of private providers. According to Svensson and Edebalk (2001: 34-5), furthermore, several municipal providers refer to the prices submitted by private ones as the benchmark with which they reflect upon their own prices. Provided that private providers mostly offer lower prices in order to win the bid, their price proposals are very likely to exert downward pressure on municipal prices. In this way, the trend of incrementally growing prices is punctuated and the price level is lowered at the time of bidding. With this model, Svensson and Edebalk showed how the growth of the whole municipal costs for elderly care services had been moderated by the participation of private providers.

However, previous studies mostly developed their discussions from time-series observation of some particular municipalities. Yet cross-sectional observation may also help us understand the influence of the participation of private providers over the cost performance of municipalities.

The cost performance of municipal providers may also be affected by the political situation. It is reasonable to assume that municipal providers make more effort to cut the costs when they feel more pressure from politics. When a municipality has strong bourgeois ideology, its public care providers may be more conscious of the possibility of being replaced with private providers. Private providers may also be more concerned about the cost performance when they make a proposal to bourgeois municipalities. From those arguments, it follows that the cost performance is better in the municipalities with strong bourgeois ideology.

Nonetheless, it is not clear whether bourgeois municipalities are more concerned about the cost. Since bourgeois politicians often regard marketization as ideologically important, they may adopt private providers more easily, i.e. with little economic consideration. In that case, private providers are less encouraged to cut costs. Municipal providers may also be discouraged

from cost-cutting effort if marketization is introduced in any case. If this is the case, a completely opposite idea comes up: marketization is less effective in the municipalities with strong bourgeois ideology. Like the share of elderly population in Hypothesis 1, the role of the political variable is inconclusive, and should be tested. The hypothesis is therefore specified as follows:

Hypothesis 2: The cost performance of elderly care is better in municipalities where marketization is introduced. The municipal political situation may affect the cost effect of marketization, although the influence may be either positive or negative.

The validity of the two hypotheses presented above is tested with the analysis of the empirical data in the next section.

3. EMPIRICAL ANALYSIS

Data and method

As already mentioned, it has been very difficult to obtain the empirical data of the elderly care services in Sweden. This is largely because of highly advanced decentralization – even the central government seems to have difficulty in collecting information from all municipalities. Table 1 above is a typical case in point – the survey method has not been historically consistent, nor the data set is complete - the figure for the home service is missing in 1998, for example. What is more, the financial data exclusively for elderly care services had not been available for a long time. The figures included the cost for the care of handicapped people, which constitutes a considerable part of the total cost.

Nonetheless, the availability of the data has improved in recent years. Since the data of 1999, the financial data for the elderly have been published separately. The costs for the care of the

elderly living in ordinary houses and the care of the elderly living in special housing accommodations are now distinguished.

It is true that the data are still too aggregate to conduct close cost analysis. With regard to the care of the elderly living in ordinary houses, for instance, the care includes various home help services such as cleaning and doing laundry, help with shopping and preparation of meals, as well as short-term special accommodations. Furthermore, around a half of municipalities provide home nursing care service under this framework. Despite that variety, we could only obtain the financial data accommodating all services.

With the available data, however, it is still possible to manage some empirical analysis, even though the estimation is nothing more than a very rough sketch. In order to establish the hypotheses in the last section, we construct two multiple regression models, one for the motives for marketization (Model 1) and the other for the cost effect of marketization (Model 2).

Model construction and estimation - Model 1

In order to establish the first hypothesis, the dependent variable of the model should be an index of the share of private providers. The care of the elderly in ordinary housing varies in duration and type, and it is difficult to define the aggregate share of private providers. On the other hand, the care of the elderly in special housing accommodations is more homogeneous, and it is less problematic to define the share of the residents of privately managed accommodations as the share of private providers. The study therefore focuses on the care in special housing accommodations. Accordingly, the model is specified as follows:

$$\begin{aligned} PVSHARE = {} & a_1 + a_2\,(BGSHARE) + a_3\,(BGDUMMY) + a_4\,(CARERATIO) \\ & + a_5\,(CARENUM) + a_6\,(POPDEN) + a_7\,(ELDSHARE) + \text{error terms} \qquad (1) \end{aligned}$$

PVSHARE = the share of the residents of privately managed accommodations in the

total number of caretakers

BGSHARE = the share of politicians of the bourgeois parties (Moderate Party, Centre Party, Liberal Party and Christian Democrats) in the municipality council

BGDUMMY = 1 where the bourgeois parties occupy the majority in the municipality council; 0 otherwise

CARERATIO = the ratio of the elderly population to the number of the caretakers = the number of elderly people per a place in special housing accommodation

CARENUM = the number of the caretakers in special housing accommodation (converted to the natural logarithm)

POPDEN = population density

ELDSHARE = the share of the elderly (defined as 65 and over) in the total population of a municipality

A complete set of the above variables is available for all 289 municipalities. The data of the political representation, the number of caretakers and the demographic structure are drawn from Valmyndigheten (the Election Authority), Socialsstyrelsen (the National Board of Health and Welfare) and Statistiska Centralbyrån (Statistics Sweden) respectively. For the political variable, a dummy variable is applied besides the crude share of bourgeois councilors, with the idea that the majority may mark an additional impact for political decision-making. The number of the caretakers in special housing accommodation is converted to the natural logarithm (CARENUM), because the distribution of the crude data is skewed too much.

The coefficients for BGSHARE (a_2), BGDUMMY (a_3), CARERATIO (a_4), CARENUM (a_5) and POPDEN (a_6) are expected to be positive according to Hypothesis 1, as it holds a larger share of private providers in the municipalities with stronger bourgeois ideology, more serious shortage of care supply, larger size of caretakers and higher population density. Since the effect of the relative size of elderly population is ambivalent, the coefficient for ELDSHARE (a_7) may

be either positive or negative, or its contribution may be just insignificant. Table 2 shows the estimates of the model.

Table 2 Estimates of Model 1. Dependent variable: PVSHARE

	Model 1
Intercept	-0.244 (-3.17)***
BGSHARE	0.234 (3.56)***
BGDUMMY	-0.017 (-0.96)
CARERATIO	0.007 (3.20)***
CARENUM	0.024 (3.40)***
POPDEN	1.35×10^{-4} (10.10)***
ELDSHARE	-0.213 (-1.34)
Adjusted R-Square	0.461
Number of cases	289

Note: t-Statistics in parenthesis; asterisks indicate statistical significance at the 1% (***) level.

The significant positive contribution of BGSHARE is consistent with the hypothesis regarding the political influence on marketization. However, the model fails to show the significance of political majority. This seems to reflect the general characteristic of Swedish municipal councils, which is rather consensual than majority-dictatorial.

The result is consistent with the hypothesis for the variables CARERATIO, CARENUM and POPDEN, all of which show significant positive contribution to the share of private providers. Moreover, the share of the elderly in the total population, ELDSHARE, indicates no significance, which supports the idea that the contribution of the variable is ambivalent.

Model construction and estimation - Model 2

The second model concerns the effect of marketization. Due to the variety of the elderly care in ordinary houses, the following model focuses on the care in special housing accommodations, as the first model. The unit cost of special housing accommodations (i.e. the cost per resident) may still vary depending on the conditions of the residents, but the variation is presumably

much smaller than the unit cost of the care in ordinary houses. The care in ordinary houses encompasses short-term special accommodations and home nursing care as well as home help services, and it is meaningless to discuss its aggregate unit cost, unless the data are classified into those types.

In the second model, therefore, the unit cost for the care in special housing accommodations is applied as the dependent variable. According to the second hypothesis, the share of private providers is to be tested as an explanatory variable. However, it is not clear whether the degree of the share is so important. After all, the share is only the result of competition, and it may be sufficient just to consider the possibility of competition, or "contestability" in an economic term.

The model should also consider the influence of municipal political ideology. Since the political variable is expected to modify the effect of marketization rather than to affect the cost performance directly, it is included in the model as a modifier of the coefficient of the marketization variable rather than an independent explanatory variable.

Besides those variables, four other variables are included in the model as the control variables. The first is the supply-demand balance, expressed as the ratio of the elderly population to the number of the caretakers, which is also applied to Model 1. The idea is that the cost is higher when there is more demand than supply. The second control variable is the number of caretakers. Since the elderly care requires various assets that can be shared by many caretakers such as furniture (even if the cost for real estate is excluded from the unit cost in the above), economy of scale has significant effect. Therefore the unit cost should be correlated negatively with this variable. The third control variable is the population density. This variable is included because there is no index to indicate the price level of municipalities directly. Here it is assumed that the cost is higher in the municipalities with higher population density. Finally, the general attitude of municipalities toward financial expenditure, expressed as the cost for municipal service per resident, is incorporated. The attitude of municipalities in this aspect

varies across different municipalities reflecting political, economic, geographical and historical backgrounds, and the cost for elderly care may well reflect it. To summarize, the analytical model is specified as follows:

$$\text{UELDCOST} = a_1 + \{a_2 + a_3(\text{BGSHARE})\}(\text{PVSHARE}) + a_4(\text{CARERATIO}) + a_5(\text{CARENUM}) + a_6(\text{POPDEN}) + a_7(\text{GEXP}) + \text{error terms} \quad (2a)$$

$$\text{UELDCOST} = a_1 + \{a_2 + a_3(\text{BGSHARE})\}(\text{PVDUMMY}) + a_4(\text{CARERATIO}) + a_5(\text{CARENUM}) + a_6(\text{POPDEN}) + a_7(\text{GEXP}) + \text{error terms} \quad (2b)$$

UELDCOST = the cost per caretaker for the care of the elderly in special housing accommodations (converted to the natural logarithm)

BGSHARE = the share of politicians of the bourgeois parties (Moderate Party, Centre Party, Liberal Party and Christian Democrats) in the municipality council

PVSHARE = the share of the residents of privately managed accommodations in the total number of caretakers

PVDUMMY = 1 where there is any resident of privately managed accommodations; 0 otherwise

CARERATIO = the ratio of the elderly population to the number of the caretakers = the number of elderly people per a place in special housing accommodation

CARENUM = the number of the caretakers in special housing accommodation (converted to the natural logarithm)

POPDEN = population density

GEXP = the total cost for municipal service per resident as an index of the municipal attitude toward general financial expenditure (converted to the natural logarithm)

The data of UELDCOST are not available for 23 municipalities for the year 2001. However, it is available for the year 2000 in 14 out of the 23 municipalities. Since the sample size is rather small, it seems to be better to add those 14 samples to the latest samples. There is certainly a risk of mixing the data of two different years, but the risk may not be so large given the stability of political and socio-economic conditions from 2000 to 2001. The number of the samples in this analysis is 280, as a result.

The unit care cost (UELDCOST) is converted to natural logarithm, on the assumption that the explanatory variables contribute to the care cost multiplicatively rather than additionally. The total cost for municipal service per resident, GEXP, is also converted to natural logarithm accordingly. There are two variations for Model 2, one with the share of the residents of privately managed accommodations (PVSHARE) and the other with the dummy variable (PVDUMMY) for the existence of private providers. Public providers may dominate the care market even if private providers are legally allowed to enter into the market. Nevertheless, market contestability is here judged to be ineffective in such a case, and the model applies the dummy variable as such. The result of the estimation is shown in Table 3.

Table 3 Estimates of Model 2. Dependent variable: UELDCOST

Variable	Model 2a	Model 2b
Intercept	7.935 (8.73)***	7.823 (8.18)***
PVSHARE	-0.691 (-2.16)**	
PVSHARE×BGSHARE	1.068 (2.08)**	
PVDUMMY		-0.133 (-2.12)**
PVDUMMY×BGSHARE		0.222 (1.76)*
CARERATIO	0.032 (8.76)***	0.032 (8.95)***
CARENUM	-0.033 (-2.64)***	-0.030 (-2.31)**
POPDEN	8.13×10^{-5} (2.94)***	6.52×10^{-5} (2.75)***
GEXP	0.435 (5.22)***	0.444 (5.06)***
Adjusted R-Square	0.277	0.278
Number of cases	280	280

Note: t-Statistics in parenthesis; asterisks indicate statistical significance at the 10% (*), 5% (**) and 1% (***) levels.

The estimation gives a support to the hypothesis about the effect of marketization. In both Model 2a and Model 2b, the coefficient of PVSHARE is significantly negative. Interestingly, the coefficient of the political variable, BGSHARE, is positive, meaning that the bourgeois ideology offsets the effect of marketization. This implies that the municipalities with strong bourgeois ideology are, somewhat paradoxically, less concerned about the effect of marketization, while they are more anxious for the introduction of marketization.

For the control variables, the results are consistent with the prior expectations for all four variables. In other words, the unit cost is likely to be higher in the municipalities with larger demand, with smaller number of caretakers, with higher population density and with more generous public expenditure policy.

5. CONCLUSION

While the marketization of elderly care is a hot political issue with increasing practices, the data availability is still far from sufficient for close analysis. On top of that, the two hypotheses presented in this paper only describe the general tendency across municipalities, ignoring any specific characteristics of every single municipality. The variety of private providers, from large business corporations to small non-profit organizations, is also neglected. Despite those deficiencies, it is still meaningful to find whether the hypotheses are applicable as general rules, for better understanding of the ongoing movement and for better policy prescriptions in the future. And the above estimations give generally good support to those hypotheses.

Regarding the motives of the municipalities for marketization of elderly care, it is verified that municipalities with stronger bourgeois ideology, more serious shortage of care supply, larger size of caretakers and higher population density are more likely to take a positive attitude toward marketization. As for the effect of marketization, the cost performance is apparently correlated both with the scale of marketization (i.e. how much is the share of private providers)

and with the presence of marketization (i.e. whether private providers are present in the market).

Along the history of the marketization of elderly care, there has been a long debate about its benefit. In that debate, the most popular question is whether private providers can achieve better performance than municipal providers. The current study does not answer that question, but it instead demonstrates the usefulness of marketization for the improvement of the overall cost performance. This is partly because private providers are good at saving costs, but more importantly because public providers also seem to improve their cost performance, encouraged by the participation of private providers. The argument here is consistent with the proposition that 'public-sector organisations will be more efficient and responsive if they are exposed to competitive pressures' in the literature of the public choice theory (Boyne 1996: 718). While the skeptics of marketization often stresses that private providers are profit-maximizers, they should recognize that municipal providers are not really different. It is necessary to give municipal providers some incentive to improve their cost performance, and market competition seems to be one of the most effective incentives.

There may well be a concern about the risk of focusing on the cost performance with no discussion on the qualitative aspect. Since there is no data of qualitative performance commonly available across municipalities, the qualitative aspect is inevitably put outside the scope of the current study. However, cost reduction should not automatically be regarded as quality deterioration by nature. Likewise, high cost does not imply high quality. In order to keep the quality of services, it is necessary to give strict guidelines and to prepare sufficient budgets, but those measures can be consistent with the introduction of market competition.

Yet just to introduce market competition does not seem to be enough. The above estimation has also revealed that the municipal political ideology is significant in that it modifies the effect of marketization in a negative way. That is, marketization is less effective in municipalities with strong bourgeois ideology, presumably because those municipalities often make marketization an objective by itself, rather than a means to achieve better cost performance. It is therefore

important to take some measures to avoid such “political noise”.

A way to avoid political bias while preserving the benefit of marketization may be to transfer the authority to choose providers from municipalities to individual caretakers, which is generally called the kundval (“customer-choice” in English), or voucher, system. In this system, caregivers should compete, but without taking account of the political preference of municipalities. Indeed, a number of municipalities have already introduced this system in various policy fields (see Svenska Kommunförbundet 2001b, for example). It would be interesting to examine the effect of the system, but that is beyond the purpose of the current study.

APPENDIX 1: Basic statistics of the variables in Model 1

Variable	Cases	Mean	Standard	Minimum	Maximum
PRVSHARE	289	0.055	0.118	0	0.654
BGSHARE	289	0.441	0.124	0.086	0.867
BGDUMMY	289	0.318	0.467	0	1
CARERATIO	289	13.41	2.879	6.782	25.32
CARENUM*	289	5.559	0.823	3.367	9.345
POPDEN	289	126.1	417.5	0.256	4,031
ELDSHARE	289	0.189	0.039	0.064	0.297

Variable	Cases	Cases 0	Cases 1
BGDUMMY	289	197	92

APPENDIX 2: Basic statistics of the variables in Model 2

Variable	Cases	Mean	Standard	Minimum	Maximum
UELDCOST*	280	12.78	0.180	12.18	13.28
BGSHARE	280	0.442	0.123	0.097	0.867
PVSHARE	280	0.057	0.120	0	0.654
PVSHARE×BGSHA	280	0.030	0.071	0	0.567
PVDUMMY	280	0.457	0.499	0	1
PVDUMMY×BGSH	280	0.219	0.251	0	0.867
CARERATIO	280	13.36	2.873	6.782	25.32
CARENUM*	280	5.575	0.820	3.367	9.345
POPDEN	280	129.4	423.7	0.256	4,031
GEXP*	280	10.59	0.125	10.27	10.97

Variable	Cases	Cases 0	Cases 1
PVDUMMY	280	152	128

BIBLIOGRAPHY

Boyne, G.A. (1996) Competition and Local Government: A Public Choice Perspective, *Urban Studies*, Vol.33, Nos.4-5, pp.703-21.

Ervik, R. and Kuhnle, S. (1996) 'The Nordic Welfare Model and the European Union' in Greve, B. (ed.) *Comparative Welfare Systems: The Scandinavian Model in a Period of Change*, London: Macmillan, pp.87-107.

Fölster, S. (1993) 'Effekter av kommunal privatisering och decentralisering' in Fölster, S. et al. *Sveriges systemskifte i fara? Erfarenheter av privatisering, avreglering och decentralisering*, Stockholm: Industriens Utredningsinstitut, pp.83-98.

International Monetary Fund, *International Financial Statistics*.

Kommissionen för rekrytering till vård och omsorg (1999) *Den ljusnande framtid är vård : om vård och omsorg - en arbetsmarknad i utveckling*, Stockholm: Regeringskansliet.

Konkurrenskommittén (1991) *Konkurrensen inom den kommunala sektorn: delbetänkande*, Stockholm: Allmänna förl, SOU 1991: 104.

Lefwerth, A. and Nordström, L. (1992) *Valfritt - om alternativa driftformer inom äldre- och handikappomsorgen*, Stockholm: Svenska kommunförbundent.

Lehto, J., Moss, N. and Rostgaard, T. (1999) 'Universal public social care and health services?' in Kautto, M., Heikkilä, M., Hvinden, B., Staffan, M. and Ploug, N. (eds.) *Nordic Social Policy: Changing welfare States*, London: Routledge, pp.104-32.

Norrman, E. and McLure Jr., C.E. (1997) 'Tax Policy in Sweden' in Freeman, R.B., Topel, R. and Swedenborg, B. (eds.) *The Welfare State in Transition: Reforming the Swedish Model*, Chicago: The University of Chicago Press, pp.109-53.

Organization for Economic Corporation and Development, *Social Expenditure Database*

Pollit, C. and Bouckaert, G. (2000) *Public Management Reform: A Comparative Analysis*, Oxford: Oxford University Press.

Porter, M.E. (1980) *Competitive strategy : techniques for analyzing industries and competitors*,

New York: Free Press.

Rosen, S. (1997) 'Public Employment, Taxes, and the Welfare State in Sweden' in Freeman, R.B., Topel, R. and Swedenborg, B. (eds.) *The Welfare State in Transition: Reforming the Swedish Model*, Chicago: The University of Chicago Press, pp.79-108.

Socialstyrelsen (1996) *Alternativa styr- och driftsformer i äldreomsorgen: Äldreomsorg på entreprenad*, SoS-rapport 1996: 8, Stockholm: Socialstyrelsen.

– (2000a) *Konkurrensutsättning och entreprenader inom äldreomsorgen*, Äldreuppdraget 99:6, Stockholm: Socialstyrelsen.

– (2000b) *Äldreuppdraget: Slutrapport, följer upp och utvärderar*, 2000:4, Stockholm: Socialstyrelsen.

– (2001) *Nationell handlingsplan för äldrepolitiken, Lägesrapport 2001*, Stockholm: Socialstyrelsen.

– (2002) *Äldre – vård och omsorg 2001*, Stockholm: Socialstyrelsen.

Svenska Kommunförbundet (2001a) *Kommunernas marknadsutnyttjande 1995-1999: en faktasammanställning*, Stockholm: Svenska Kommunförbundet.

– (2001b) Valfrihet och kundvalssystem i kommunal verksamhet – underlag för lokala bedömningar, Stockholm: Svenska Kommunförbundet.

– and Statistiska Centralbyrån (2001) *Vad kostar verksamheten i Din kommun? Bokslut 2000*, Stockholm: Statistiska Centralbyrån.

– and Statistiska Centralbyrån (2002) *Vad kostar verksamheten i Din kommun? Bokslut 2001*, Stockholm: Statistiska Centralbyrån.

Svensson, M and Edebalk, P.G. (2001) *90-talets anbudskonkurrens i äldreomsorgen: några utvecklingstendenser*, IHE Arbetsrapport, 2001:1, Lund: Institutet för hälso- och sjukvårdsekonomi.

Trydegård, G. (2001) 'Valfärdstjänster till salu' in Szebehely, M. et al., *Välfärdstjänster i omvandling*, Stockholm: Fritzes, SOU 2001: 52, pp.77-139.